

You may use this form for automatic reimbursement each month if you are required to pay monthly amounts even when you do not require care due to illness, vacation, etc.

### INSTRUCTIONS

1. Please fill in all fields legibly. Missing information could cause a delay in processing.
2. Check the box below\* to start a recurring claim or to change or stop an existing claim.
3. It is your responsibility to notify Allegiance of any changes in a timely manner.
4. You can fax your completed form to 1-877-424-3539, or complete and save form, login to the portal and file a claim.

EMPLOYER NAME:	DATE:
EMPLOYEE NAME:	PARTICIPANT ID NUMBER:

Start\*                       Change\*                       Stop\*

Dates rates are effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Please make sure dates are within your current Plan Year)

The provider charges \$ \_\_\_\_ per month and TOTAL \$ \_\_\_\_ per contract range. (example \$100 per month x 12 months total would be \$1,200.00 per contract range.)

Dependent(s) for whom care will be provided:	

Provider's Name	Provider's Signature
Provider's Tax ID Number	

Some examples of ELIGIBLE expenses:	Some examples of INELIGIBLE expenses:
<ul style="list-style-type: none"> <li>Day Care Centers</li> <li>Elder Care</li> <li>Family Child Care</li> <li>Day Camps</li> <li>Preschool</li> <li>After School Care</li> <li>Nanny / Au Pair</li> </ul>	<ul style="list-style-type: none"> <li>Meals</li> <li>Overnight Camps</li> <li>Diapers</li> <li>Education expenses, including Kindergarten</li> <li>Incidental fees, such as activity fees and field trips</li> </ul>

Claims are paid with the funds available in your account at the time your payment comes due. Unpaid balances continue to be paid as funds become available.

I certify that stated payment amounts are due to the provider even if absences occur during any billing period.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_